Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY HEALTH SYSTEM
4502 MEDICAL DR
SAN ANTONIO TX 78229-4402

Respondent Name
Service Lloyds Insurance Co

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-2448-01

MFDR Date Received
March 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CONTINUITY OF CARE"

Amount in Dispute: $242.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was not enrolled in any known carrier-related network on this date of service."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2011	Outpatient Hospital Services	$242.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 29, 2011
   - 196 – Non Network Provider
   - B5 – Pymnt Adj/Program guidelines not met or exceeded
   - TC – Technical Component

Explanation of benefits dated December 8, 2011

- 193 – Original payment decision maintained
- 196 – Non Network Provider
- B5 – Pymnt Adj/Program guidelines not met or exceeded
- TC – Technical Component

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care not [emphasis added] delivered, or arranged by a certified workers" compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, the division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

2. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307; for that reason, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.